

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10180

CERTIFICATE OF DEATH

Reg. Dist. No.

10160

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES RICHARD Coates</u>		4. DATE OF DEATH Month Day Year <u>Sept 22, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1936</u>
9. AGE (In years last birthday) <u>23</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilson T. Coates</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Coates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT Address <u>Mary Ann Toye, Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture - Dislocation of 6th Cervical Vertebra & Transection of Spinal Cord.</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 DAYS</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident Sept 19/59 (Car off road)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>23 Church Road</u>		20f. (City or town) (County) (State) <u>Charles Md.</u>	
21. I certify that I attended the deceased from <u>Sept 19, 1959</u> , to <u>Sept 21, 1959</u> that I last saw the deceased alive on <u>Sept 21, 1959</u> , and that death occurred at <u>10:36 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. PARRAN JARBOE</u> M.D.		DATE SIGNED <u>9-22-59</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Shunt Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 25 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur H. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>47X-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Mem Hosp</i>		d. STREET ADDRESS <i>614 Orleans Pl NE</i>	
3. NAME OF DECEASED (Type or print) <i>ROBERT MORRIS DIGGS</i>		4. DATE OF DEATH <i>SEPT 29 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5 1903</i>
9. AGE (In years last birthday) <i>56 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Isaac Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Ernest Diggs</i>	
17. INFORMANT <i>Ernest Diggs</i>		Address <i>Washington DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Liver</i> 823X and DUE TO (b) <i>Bilateral Hemothorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Multiple Rib Fractures</i>		INTERVAL BETWEEN ONSET AND DEATH <i>46 h.</i> <i>46 h.</i> <i>46 h.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Hemorrhage</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger-auto accident-Potomac River Bridge</i>	
20c. TIME OF INJURY Month, Day, Year <i>12 noon 9-27 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>RT. 301</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>NEWBERG, CHARLES, MD.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Detton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>9-29-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-3-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		22d. LOCATION (City, town & county) (State) <i>MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.D. Bacon</i>		ADDRESS <i>1722 7th St NW</i>	
24a. REC'D BY REGISTRAR <i>DOCT 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur A. King</i>	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1921

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

11/11/21

10182

CERTIFICATE OF DEATH

Reg. Dist. No.

10162

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Gill Bowling Forbes Edelen</u>				4. DATE OF DEATH <u>Sept 26 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17 1875</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Forbes Edelen</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Bowling</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Edward G. Edelen, Bryantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>20 YEARS</u> <u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>SEPTEMBER, 1947</u> to <u>SEPT. 26, 1959</u> , that I last saw the deceased alive on <u>SEPTEMBER 26, 1959</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Griffin</u>				ADDRESS (Street, city or town, state) <u>Box 65, Hughesville, Md.</u>			
DATE SIGNED <u>9/27/59</u>				PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN</u>			
Box 65, Hughesville, Md.				9-27-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Halloway, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR	
DATE <u>OCT 1 '59</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF INTERMENT

DATE OF BURIAL

DATE OF CREMATION

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REBURYAL

DATE OF RECREATION

DATE OF RECONSTRUCTION

DATE OF REFORMATION

DATE OF REGENERATION

DATE OF REDEMPTION

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

DATE OF REDELIVERANCE

10183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY SMITH ELSEBOUGH</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12 1875</u>
9. AGE (In years last birthday) yrs. <u>84</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>84</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Long Island N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Elsebough</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>080-099468</u> INFORMANT Address <u>L Kiernan Indian Head</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4 Acute Cardiac Dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic cardiac failure</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 min</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>9-14</u> , 19 <u>59</u> , to <u>9-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>59</u> , and that death occurred at <u>9-14</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. J. Lina</u> M.D.		DATE SIGNED <u>9-14-59</u>	
PHYSICIAN'S NAME (Type) <u>La Plata, Md.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezers</u>	22d. LOCATION (City, town, or county) (State) <u>Long Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. La Plata</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
ISM 9/58

10/10/10

10/10/10 10/10/10

10/10/10

10/10/10

(10/10/10)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10168
Item 9 Film G249 10/2/59 iwk										
10184										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JEANNETTE B HOUGH					4. DATE OF DEATH Month SEPT Day 24 Year 1959					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1887		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME Byron Gibbons					14. MOTHER'S MAIDEN NAME Elizabeth Dougherty					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. INFORMANT Mrs Ralph Black London Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic asthmatic condition DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 years.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1957, to Sept 24, 1959, that I last saw the deceased alive on Sept 15, 1959, and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. M. Johnson M.D. La Plata Md 9-24-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) F. M. JOHNSON										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)				
Burial		9-26-59		Cedar Hill		Suitland Md				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1071087

1071087



10185

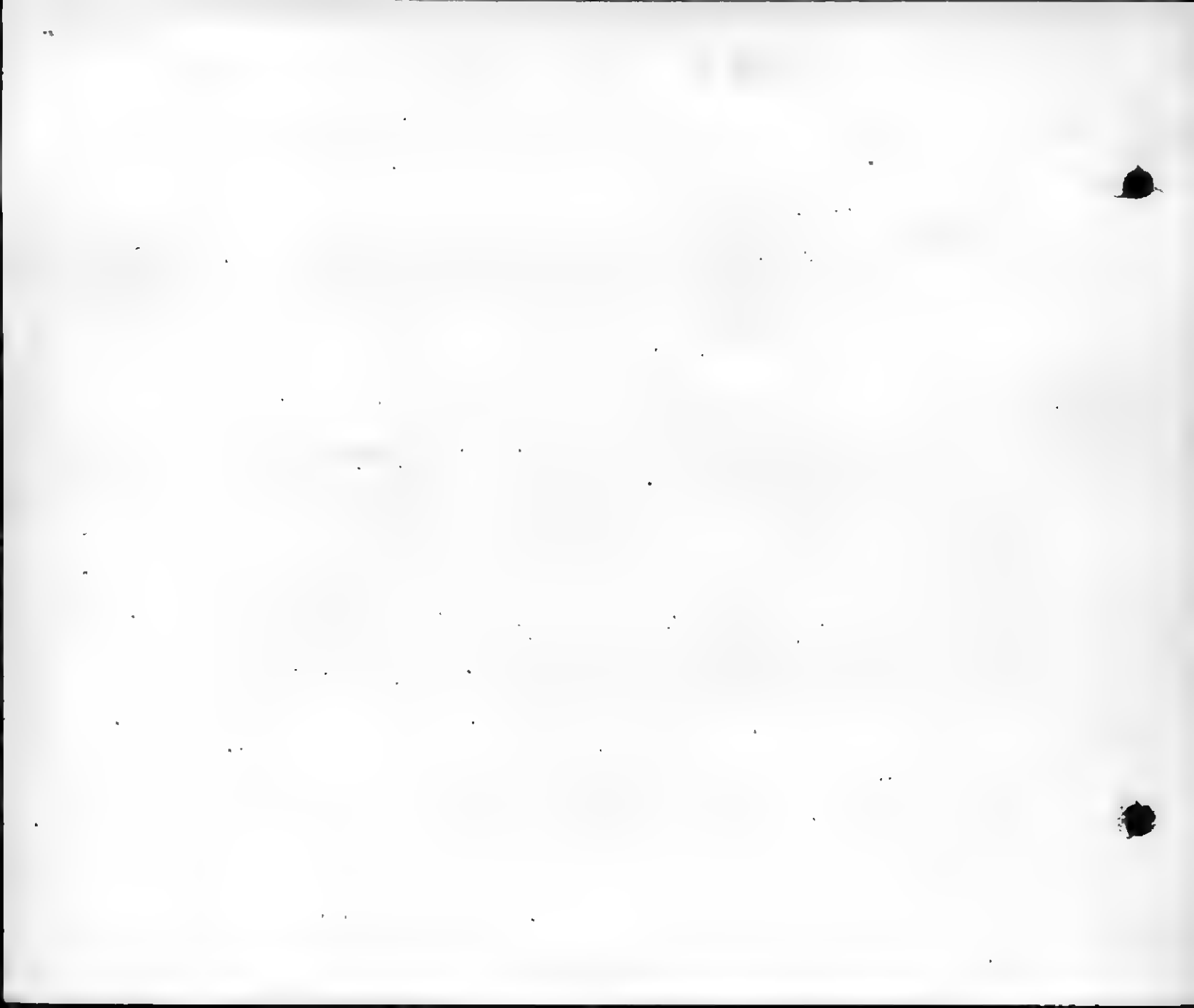
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
		f. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First RUTH Middle HALL Last MALCOLM		4. DATE OF DEATH Month SEPT Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1874
9. AGE (In years last birthday) 85 yrs		10. FINDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Milford, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Bartell		14. MOTHER'S MAIDEN NAME Louisa M. La Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. C.J. Gridley - La Plata, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertension DUE TO Heart Failure (c) Stroke PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of Hypertension in Mother		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week 2 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Heart attack	
20c. TIME OF INJURY Month May Day 9 Year 1959 Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) La Plata Charles, Md	
21. I certify that I attended the deceased from 1959 to 1959 that I last saw the deceased alive on Sept 6 , 19 59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Jones		DATE SIGNED SEP 7 1959	
PHYSICIAN'S NAME (Type) Richard H. Jones		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/1959	
22c. NAME OF CEMETERY OR CREMATORY Everview Cemetery		22d. LOCATION (City, town, or county) (State) Apache Oklahoma	
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Jones		24a. REC'D BY REGISTRAR SEP 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Jones			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x La Plata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>McPHERSON</u> Last <u>N</u>				4. DATE OF DEATH Month <u>sept</u> Day <u>20</u> Year <u>19</u>			
5. SEX <u>P</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13 1902</u>	9. AGE (In years last birthday) <u>57</u> yrs	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank McPharson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Norris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Katie Cager, La Plata, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Hypertension</u> DUE TO (c) <u>16 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept -</u> , 19 <u>56</u> to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>57</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>Oct 28-59</u> ACTUAL SIGNATURE <u>John V. McPherson</u> M.D. <u>La Plata, Md.</u> PHYSICIAN'S NAME (Type) <u>John V. McPherson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Evans</u>	

1

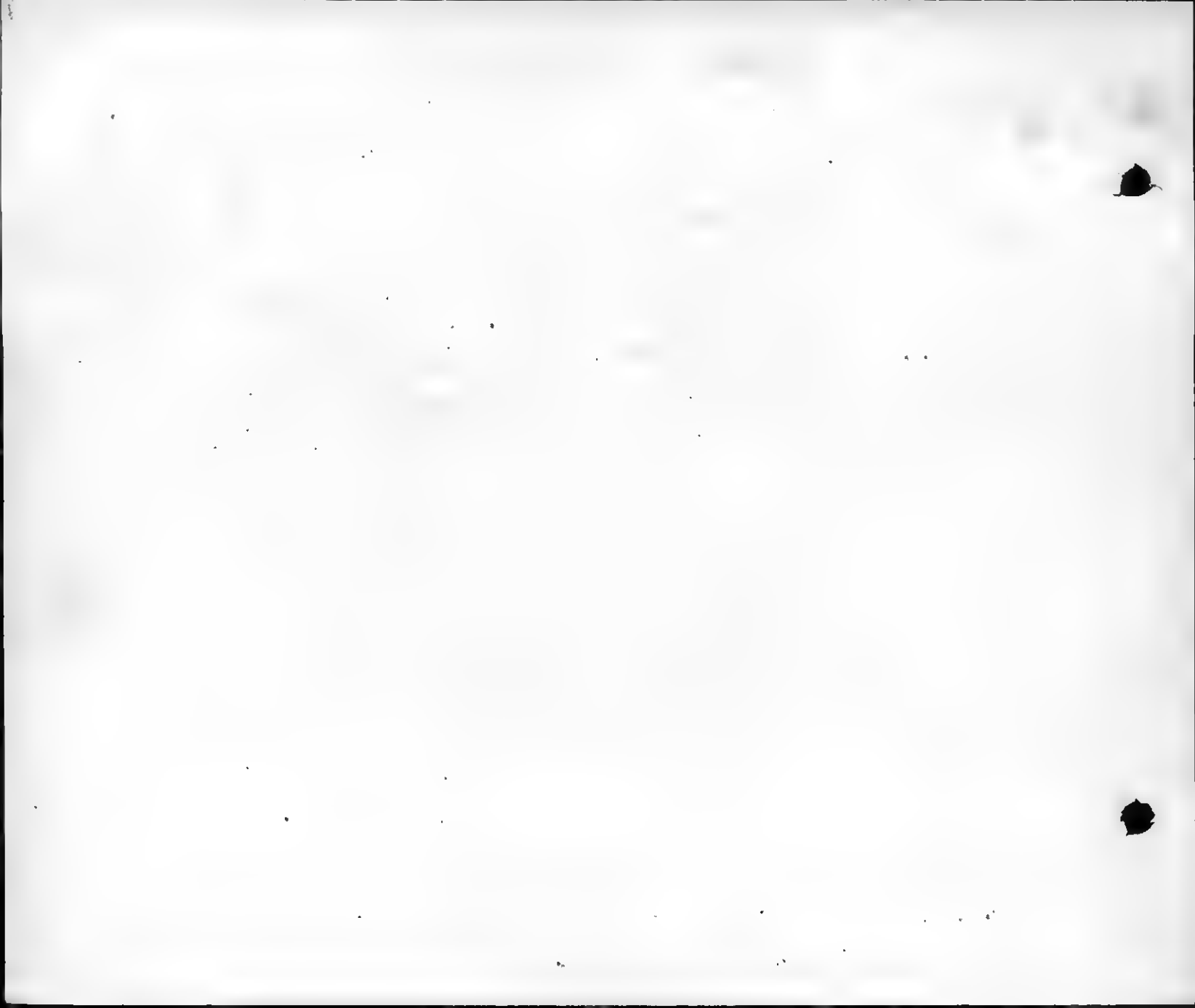
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

066

1

VS A15 (4)
15M 9/7



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

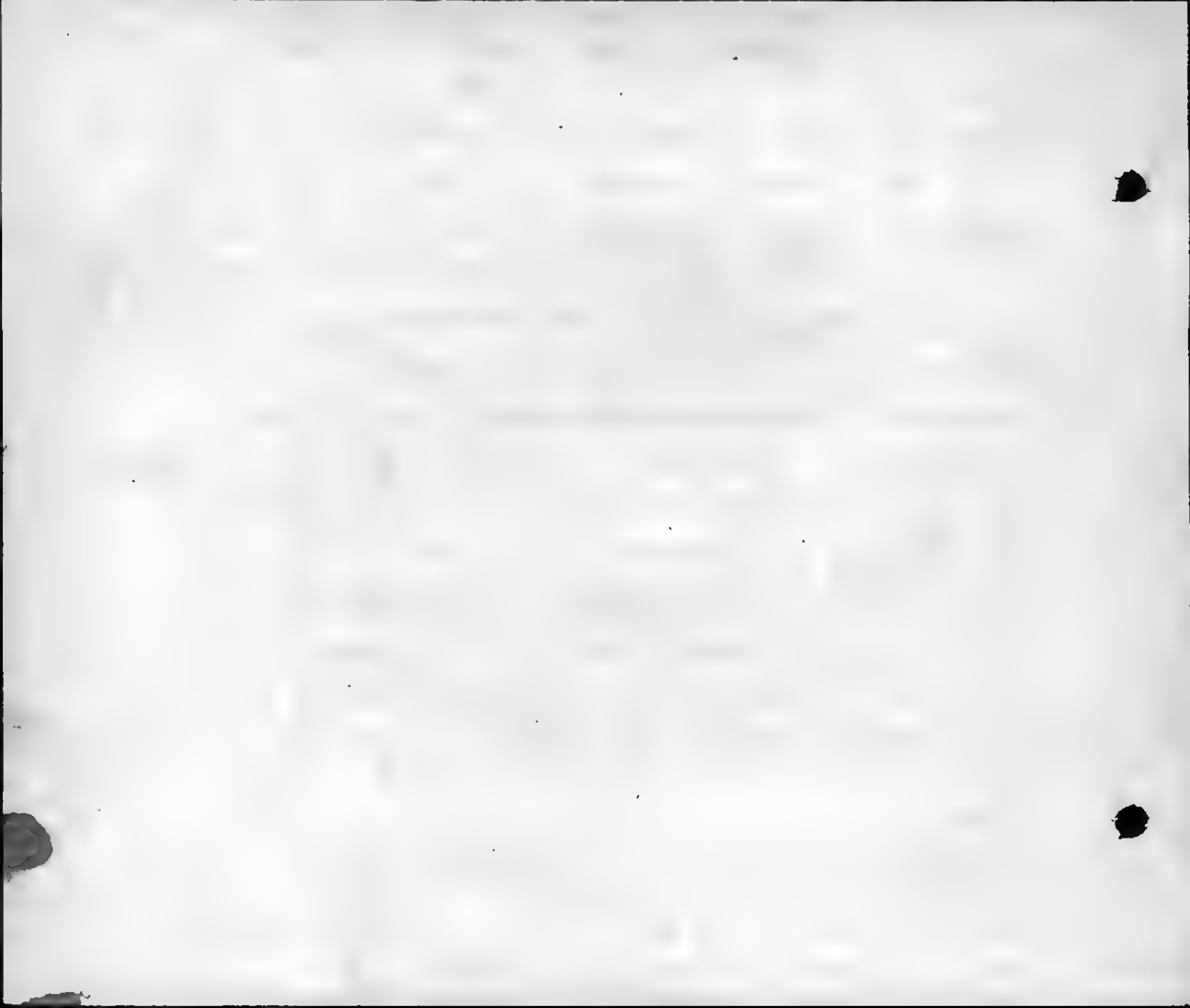
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Washington b. COUNTY Dc c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 477 d. STREET ADDRESS 911 M St N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADA First VALERIE Middle MITCHELL Last 4. DATE OF DEATH SEPT. 27 Month 1959 Day Year		5. SEX F 6. COLOR OR RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH SEP 10, 1909 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signer 10b. KIND OF BUSINESS OR INDUSTRY Copating 11. BIRTHPLACE (State or foreign country) Fayetteville N.C. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 110101010 17. INFORMANT Wloyds Mc Gray Address 911 M St N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Subarachnoid Hemorrhage Conditions, if any, which gave rise to immediate cause (b) and Crush Injuries of Chest (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 1 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Passenger auto accident - struck abutment 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 12:00 AM 9-27-59 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work U.S. 301 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NEWBURG, CHARLES, MD. 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE V.B. DETTOR EXAMINER'S NAME (Type) V.B. DETTOR M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 105-59 22b. DATE THEREOF 10-27-59 22c. NAME OF CEMETERY OR CREMATORY 105-59 22d. LOCATION (City, town, or county) (State) 105-59		23. FUNERAL DIRECTOR'S SIGNATURE 105-59 ADDRESS 105-59 24a. REC'D BY REGISTRAR 2 '59 24b. REGISTRAR'S SIGNATURE 105-59	



10188

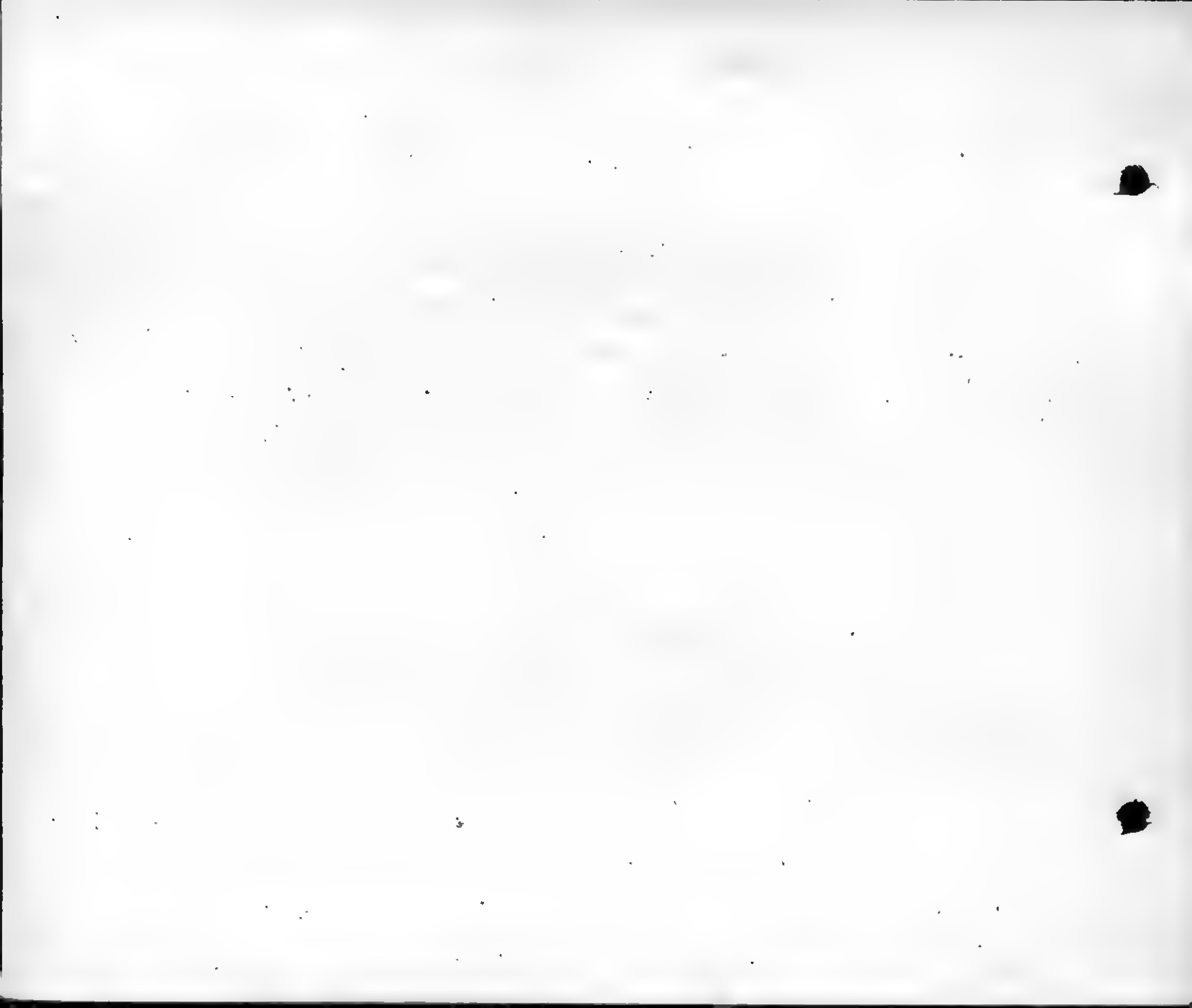
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point		c. LENGTH OF STAY IN 1b Appr. 60 yrs	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point	
3. NAME OF DECEASED (Type or print) Luther Arnold PRICE		4. DATE OF DEATH sept 24 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 22 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder		10b. KIND OF BUSINESS OR INDUSTRY Waterman	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Martin Luther Price		14. MOTHER'S MAIDEN NAME Lucy Ashton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mary M. GONONG, Alex, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Croup occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c)		INTERVAL BETWEEN ONSET AND DEATH minutes 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal cell carcinoma face.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Jan , 19 51 , to 10 Aug , 19 59 , that I last saw the deceased alive on 24 September , 19 59 , and that death occurred at 6: AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Wooddy		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 25 Sept 59	
PHYSICIAN'S NAME (Type) Arthur O. Wooddy, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-26-59	22c. NAME OF CEMETERY OR CREMATORY Holy Ghost	22d. LOCATION (City, town, or county) (State) Issue, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The Shmidt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR SEP 30 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur A. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10169

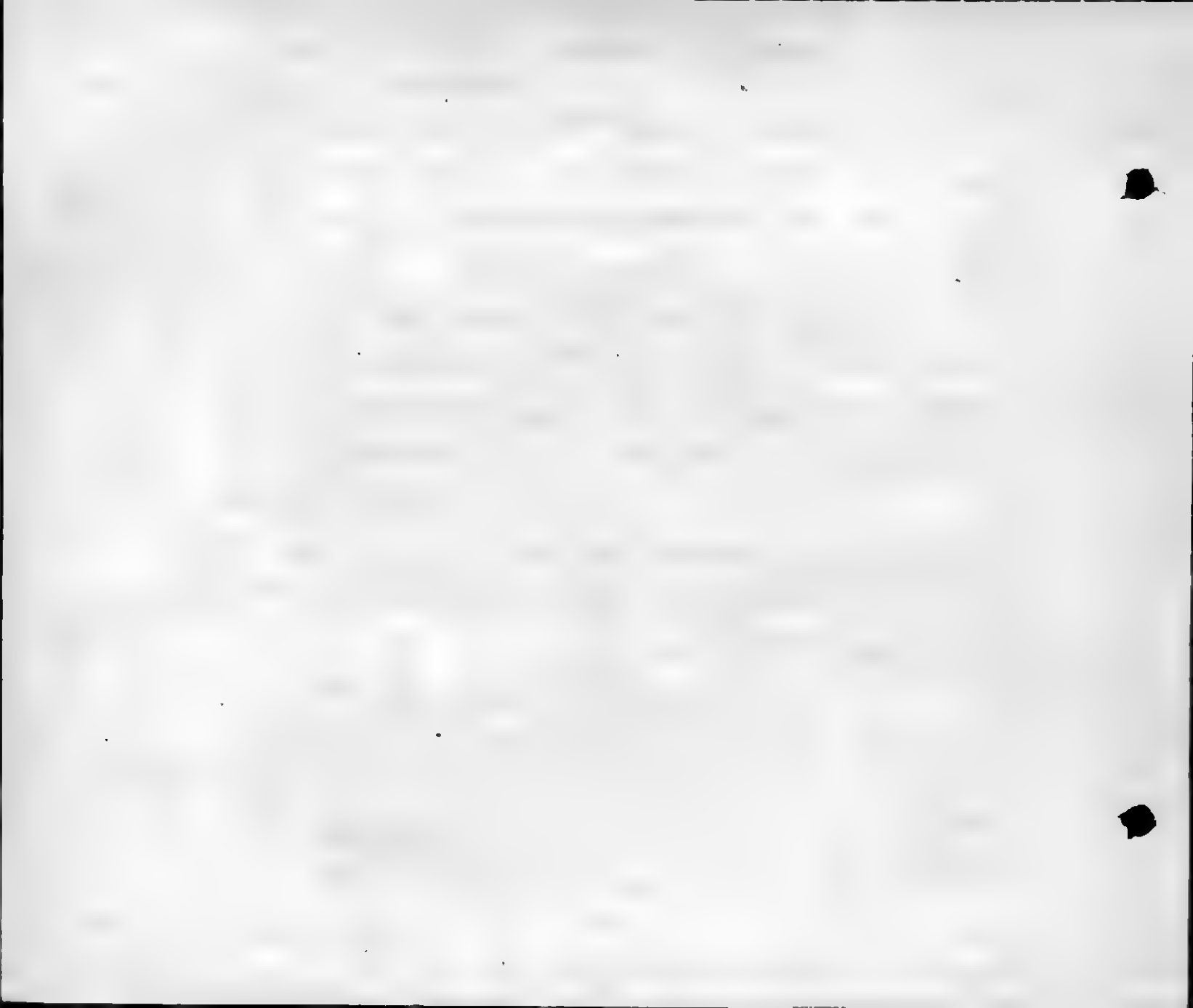
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i> c. LENGTH OF STAY IN 1b <i>20 min</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pisgah</i> d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>AGNES YVONNE PROCTOR</i> First Middle Last		4. DATE OF DEATH Month <i>SEPT.</i> Day <i>15</i> Year <i>19 59</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV 13 1937</i>	9. AGE (In years last birthday) <i>21</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>George C. Gray</i>		14. MOTHER'S MAIDEN NAME <i>Annie Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-34-7045</i>		17. INFORMANT <i>John Proctor, Pisgah, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock and hemorrhage</i> DUE TO (b) <i>Rupture of Pregnant uterus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>30 min.</i> <i>30 min.</i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident - Route 301 and 6</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>0745</i> <i>9-15</i> 19 <i>59</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>La Plata</i>	(County) <i>Charles</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>V.B. Jettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>9-15-59</i>	
EXAMINER'S NAME (Type) <i>V.B. JETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-19-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Catherine</i>	22d. LOCATION (City, town, or county) <i>Mc Conchie</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>SEP 22 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Curtis & Friend</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



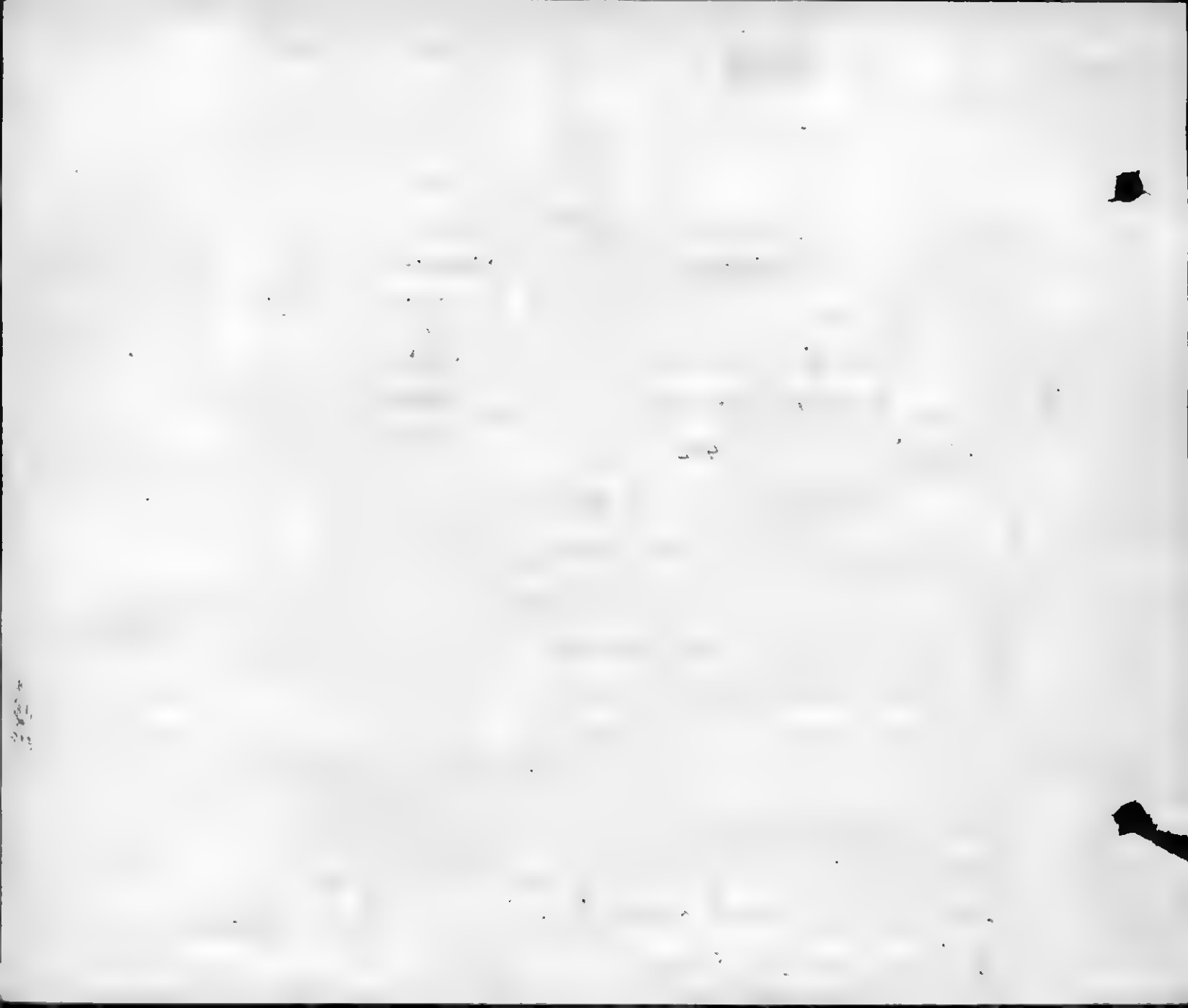
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NY b. COUNTY NASSAU	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seaford - Long Island	
c. LENGTH OF STAY IN 1b 2 1/2 hrs.		d. STREET ADDRESS 67X-J	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIAN'S MEMORIAL HOSPITAL			
3. NAME OF DECEASED (Type or print) Francis First Rosen Last		4. DATE OF DEATH SEPTEMBER 15 1959 Month Day Year	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hawf.		10b. KIND OF BUSINESS OR INDUSTRY Palmd	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Joseph Osman		14. MOTHER'S MAIDEN NAME Becky Zepnick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO yes - unknown	
17. INFORMANT Benjamin Rosen - Seaford, L.I. N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Crush injuries of chest (c) Crush injuries of chest		INTERVAL BETWEEN ONSET AND DEATH 2 h. 45 min. 2 h. 45 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scleroderma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Auto Highway accident - Rt. 301 and 6	
20c. TIME OF INJURY Month, Day, Year 7:30 a.m. 9-15-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) LA PLATA CHARLES, MD. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE V. B. Dettor		DATE SIGNED 9-15-59	
EXAMINER'S NAME (Type) V. B. DETTOR, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/59	
22c. NAME OF CEMETERY OR CREMATORY Beth Davis Cem		22d. LOCATION (City, town, or county) Long Island, NY (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargonsky Sons 3501 14th St NW		24a. REC'D BY REGISTRAR Arthur S. Kline 24b. REGISTRAR'S SIGNATURE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

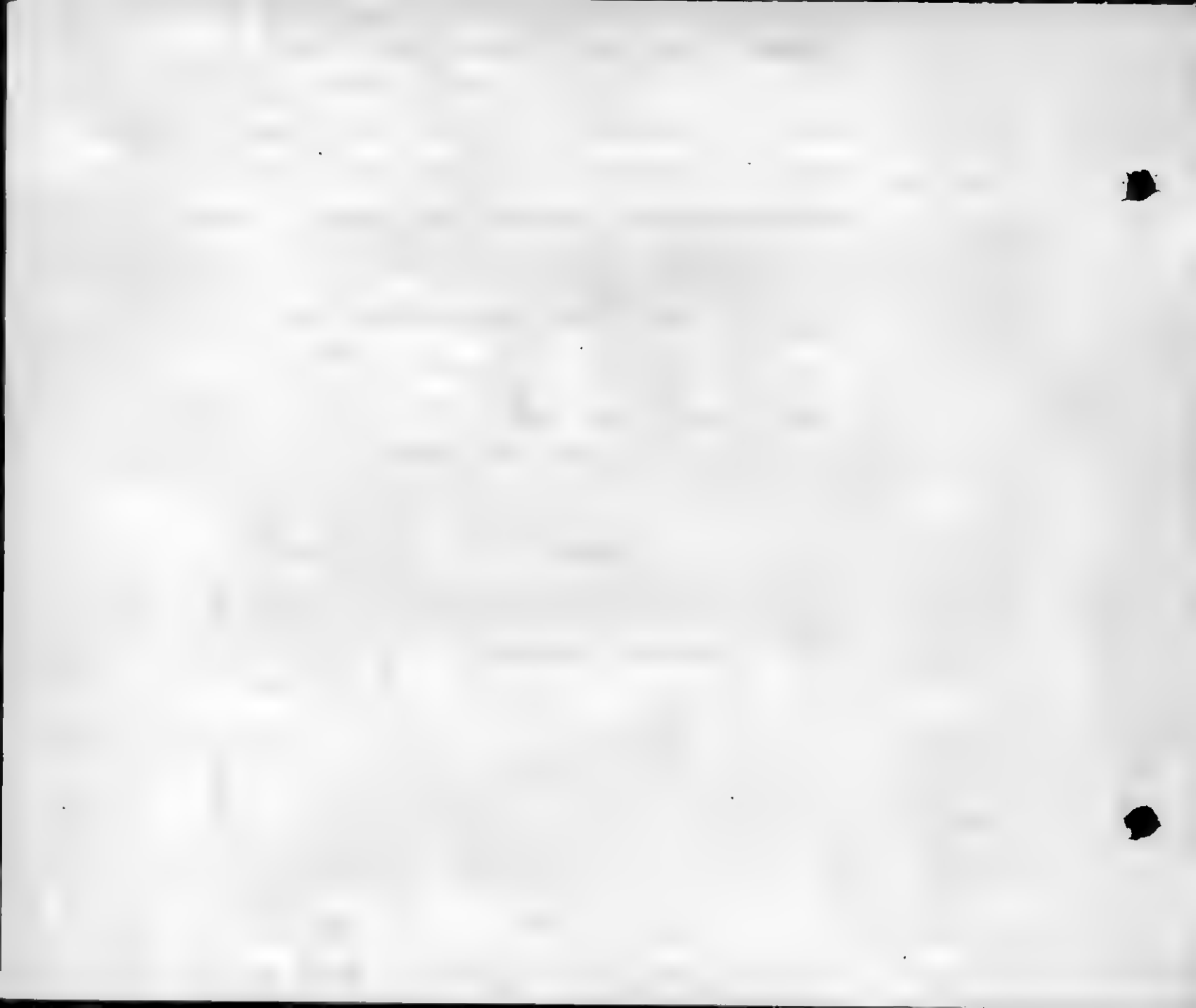
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waldorf</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf-Rural</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PHILLIP Edward SEMBLY</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 1 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1927</u>		9. AGE (in years and birthday) <u>17</u> yrs.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Sembly</u>				14. MOTHER'S MAIDEN NAME <u>Ella Browner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
				17. INFORMANT <u>121 Quincy Pl. N.E. Washington 2, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 min.</u> (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH: <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collapsed while walking to house</u>			
20c. TIME OF INJURY Month, Day, Year <u>9-1 1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
				20f. (City or town) (County) (State) <u>Waldorf, Charles, Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>V.B. Dettor</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-5-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>				22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Rural Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>C. L. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10191

CERTIFICATE OF DEATH

Reg. Dist. No.

10172

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Issue (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS DOUGLAS SWANN First Middle Last		4. DATE OF DEATH Sept 24 1959 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Ross Swann		14. MOTHER'S MAIDEN NAME Cecelia Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Address Mrs. Annie L. Swann (Wife), Issue, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 acute cardiac debilitation DUE TO (b) Cor Pulmonale DUE TO (c) Emphysema (pulmonary) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min 5 years 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1956 , to Sept 24, 1959 , that I last saw the deceased alive on Sept 24, 1959 , and that death occurred at 7:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md DATE SIGNED 9-24-59 ACTUAL SIGNATURE For Johnson M.D. PHYSICIAN'S NAME (Type) La Plata, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/1959	22c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery	22d. LOCATION (City, town, or county) (State) Issue, Charles Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur & Thomas ADDRESS AREHART FUNERAL HOME, INC., La Plata, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '59	24b. REGISTRAR'S SIGNATURE Arthur & Thomas

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the ban poster. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

10192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Evermont (one) Whitman</u>				4. DATE OF DEATH <u>9-19-59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W-US</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer-Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky-District-West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Holly Jackson Whitman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Cottle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
				17. INFORMANT Address <u>Pauline Tedrick (Daughter) Oxon Hill Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1-Hour</u> <u>Indefinite</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-58</u> , 19____, to <u>9-19-59</u> , 19____, that I last saw the deceased alive on <u>9-19-59</u> , 19____, and that death occurred at <u>8:30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. <u>Indian Head Md</u> <u>9-19-59</u> PHYSICIAN'S NAME (Type) <u>James E. Andrews, Indian Head Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Archant Inc La Plata Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

